

HB 6521

Dear Chairperson and Public Health Committee Members,

I am writing to you support of H.B. No. 6521 (Raised) An Act concerning Medical Orders for Life Sustaining Treatment (MOLST).

I would have preferred to present my testimony in person but unfortunately I had to be out of the state this week.

You will hear testimony from several of the members of the task force that came together to support this legislative effort. I expect you will have questions about how the MOLST differs from an Advance Directive or Living Will. It has been my experience that the best way to explain a new concept is with real life examples.

I have been a practicing Emergency Physician for the past 23 years. In my career I have had many opportunities to discuss goals of care with patients and their families. As you might imagine the Emergency Department is often the place where these conversations occur in a crisis situation, with physicians, patients and families who have only just met each other. Not an ideal environment for making such important decisions.

Many of our patients make the effort to complete an Advance Directive and are under the impression that it will speak their wishes when they are no longer able to speak for themselves. For some this holds true, unfortunately for others this is not necessarily the case.

While the intent of both documents is to give the individual a means to state their wishes for care at the end of life, the Advance Directive is static and the MOLST is dynamic. MOLST anticipates a need for, allows for and documents any changes in preferences that a pt may wish to make. An Advance directive or living will has no area to notate a change in preferences that a pt may make whether it be reversing previous limits or adding new ones. Unlike the living will, a MOLST can demonstrate chain of evidence so to speak of how the pts current preferences may have evolved. In contrast a living will indicates a preference at a specific moment in time and it generally lacks any standard mechanism or notation to indicate if it remains the current preference. This was highlighted all too clearly in a recent encounter I had over several hours with a patient and family.

I will give you as much detail as I can without threatening the privacy of those involved. It is the story of a very elderly parent in her mid 90's. She had a legally executed Advance Directive which clearly stated that she would not want artificial ventilation or nutrition if she were found to be in a terminal condition. She had signed this document herself in 2007 prior to her onset of dementia. Now she had suffered acute and rapid decline in her abilities in breath and in fact on my examination was actively dying. She was in terrible distress. she was terminally ill based on her underlying condition. Her living will also identified her Health Care Proxy. The Health Care Proxy indicated that patient would not want any further life-sustaining therapy but to have treatment aimed at her comfort. The only other next of kin was another adult child who lived out of state. From my conversation I could tell that he was struggling with the news that

his parent was critically ill. He requested that we temporarily put her on life support to give her a chance. He was surprised to hear that she in fact had a living will and that I intended to follow her directions indicated by the document. The son conceded that while the living will was legal he felt that in a recent conversation she indirectly revoked the document when she promised to pay better attention to her nutrition. There were no other witnesses to this encounter. I expressed my medical opinion that any interventions other than aggressive symptom management would only prolong her suffering and were in direct contrast to her advance directive. He wanted to know how I could possibly consider following the directions she laid out over 6 years ago and he emphasized the fact that "her doctor wasn't even involved in this, it was done with her lawyer." The health care proxy had tried to convince him that the patient would not want any of what he was asking for but he insisted.

Meanwhile, the patient lay in a hospital bed suffering and in obvious distress. She did not have the capacity at this point to be asked directly, though she continued to say "Please, I'm so tired". I did not have consensus from the family, there was a challenge to the existing living will and I was forced to get guidance from our administration. I was instructed to place her on life support and we would deal with the repercussions with In the morning.

This patient suddenly lost her autonomy and right to choose, despite having made all the efforts our state allows to record directives for treatment at the end of life.

A MOLST is a document created in consultation with the patients care provider. It allows for changes and encourages review of goals of care with changes in the patients health status. The static nature of the Living Will and the fact that there was little evidence that these wishes had ever been reviewed with the patient and her physician in the recent past allowed for enough doubt that the validity of this patient's living will was called into question. Had the son seen evidence of continued affirmation of her prior wishes the situation may have been different.

As I stated earlier I have the past spent 23 years in the Emergency Medicine. For the past several years I pursued further training in Palliative Medicine, a relatively new medical specialty which brings a team approach to provide an extra layer of support to patients and families facing serious illness. As a Board Certified member of both specialties in I fully support any program that encourages the discussion of goals of care between a patient and the care provider with whom they have a trusted relationship to ensure that the care provided in all settings is consistent with those goals. I invite you to please contact me if I can be of any further assistance as you weigh the benefits of this legislation.

Respectfully,
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